



The Scottish Parliament  
Pàrlamaid na h-Alba

## HEALTH AND SPORT COMMITTEE

### AGENDA

5th Meeting, 2015 (Session 4)

Tuesday 17 February 2015

The Committee will meet at 9.45 am in the Robert Burns Room (CR1).

1. **Decision on taking business in private:** The Committee will decide whether its consideration of its approach to NHS Boards Budget Scrutiny should be taken in private at future meetings.
2. **Assisted Suicide (Scotland) Bill:** The Committee will take evidence on the Bill at Stage 1 from—
  - Patrick Harvie MSP, member in charge of the Bill;
  - Andrew Mylne, Head of Non-Government Bills Unit;
  - Louise Miller, senior solicitor, Office of the Solicitor to the Scottish Parliament;
  - Amanda Ward, adviser to Patrick Harvie.
3. **Assisted Suicide (Scotland) Bill (in private):** The Committee will consider the main themes arising from the oral evidence heard earlier in the meeting.

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The papers for this meeting are as follows—

**Agenda Item 2**

Written Submissions	HS/S4/15/5/1
PRIVATE PAPER	HS/S4/15/5/2 (P)
PRIVATE PAPER	HS/S4/15/5/3 (P)
SPICe Briefing	HS/S4/15/5/4
PRIVATE PAPER	HS/S4/15/5/5 (P)

**Assisted Suicide (Scotland) Bill**

**James Chalmers**  
**Regius Professor of Law at the University of Glasgow**

**Response to Question Paper: The Position under Existing Scots  
Criminal Law**

1. Thank you for your email of 28 January inviting me to answer several questions regarding the criminal law of Scotland in relation to assisted suicide. I have done so below, as fully as possible in the time available. Although this is a relatively lengthy note, the core conclusion is a simple one: the scope of the criminal law in this area cannot be stated with any degree of certainty whatsoever.

**Introductory comments**

2. The initial difficulty with answering the questions raised by the committee is that the most fundamental issue arising in this context is unclear. Remarkably, it is not known whether or not suicide is itself a criminal offence in Scots law. This uncertainty colours the entire debate thereafter, as follows:
  - If suicide is itself a criminal offence in Scots law, then the criminal liability of anyone who assists in a suicide falls to be determined by applying the general principles of “art and part liability” recognised by the law – that is, the same principles which govern the liability of anyone who is alleged to have assisted in the commission of a criminal offence. The position would be similar to that in English law before the Suicide Act 1961 where, because suicide was “self-murder and therefore a felony... a person who aids, abets, counsels or procures another to commit suicide [was] guilty of murder” (*Criminal Law Revision Committee: Second Report (Suicide)* (Cmnd 1187: 1960) para 3).
  - If suicide is not a criminal offence in Scots law, then liability for assisted suicide could arise only when the person who has provided assistance can in law be said to have caused the death of another person, and to have done so with the degree of fault required for guilt of either murder or culpable homicide. The potential scope of liability would be narrower in this scenario.
3. It is commonly asserted that suicide is not a criminal offence in Scots law. For example, an article published in the *Juridical Review* in the aftermath of the decision in *R (on the application of Purdy) v DPP* [2010] 1 AC 345 included the following statement:

“Suicide has never been a crime in Scotland. There is no Suicide Act or equivalent...” (SAM McLean, C Connelly and JK Mason, “*Purdy* in Scotland: we hear, but should we listen?” 2009 JR 265 at 276.)
4. The authors, however, cite no authority for this claim. It is not clear what they mean to imply by pointing to the absence of an equivalent of the (English) Suicide Act 1961, because the effect of that Act was to

*decriminalise* suicide in English law. If English law had no Suicide Act, suicide would remain a criminal offence there.

5. The authors are not alone in suggesting that suicide is not criminal in Scots law (see e.g. RAA McCall Smith and D Sheldon, *Scots Criminal Law*, 2<sup>nd</sup> edn (1997) 171; PR Ferguson, "Killing 'without getting into trouble'? Assisted suicide and Scots criminal law" (1998) 2 Edin LR 289 at 290.) But no such claim is found in the leading modern text on Scots criminal law (G H Gordon, *The Criminal Law of Scotland*, 3rd edn by MGA Christie, 2 vols (2000-2001)) and as I have explained elsewhere, such a claim is unsafe and may rest on a failure to appreciate how the issue of criminal liability for suicide was historically far more likely to be an actual issue in English law than Scots law:

"It is sometimes asserted that suicide simply is not a crime in Scotland, in contrast to the pre-1961 English position. In fact, the distinction between the two jurisdictions seems more a consequence of ancillary rules rather than a difference in substantive criminal law. The older Scottish writers do regard suicide as criminal in nature, but with little or no scope for such an act to be regarded as criminally *punishable*. In England, by contrast, the forfeiture of a suicide's goods and chattels, in conjunction with the system of coroner's courts, gave practical application to the theory that suicide was a felony: the point was 'argued backwards' from forfeiture to criminality.

It might be objected that if suicide were considered a criminal offence in Scots law, then this should have been evidenced by way of prosecutions for attempted suicide. The absence of such prosecutions, however, seems to have had more to do with the lack of any general theory of attempts in Scots law prior to 1887. Although there is now a general rule that any attempt to commit a crime is itself criminal, it seems that attempted suicide has not in practice been treated as a crime *per se* in Scots law, no doubt because if a prosecution were felt necessary resort might be made to the offence of breach of the peace." (J Chalmers, "Assisted suicide: jurisdiction and discretion" (2010) 14 Edin LR 295 at 298-299, citations omitted; available at <http://eprints.gla.ac.uk/70278/1/70278.pdf>.)

6. The question whether suicide is itself criminal in Scotland remains open for the courts to determine should it arise. It may be that it is more likely that it will be determined one way rather than the other, but it is doubtful that making any such prediction would be helpful. The fact that the question remains arguable is simply indicative of the lack of legal certainty in this area.

### Question 1

7. You have asked me for the following:

"...views on which of the behaviours on the spectrum of assistance you consider might reasonably [be] regarded as currently lawful or unlawful in Scotland. In particular, can you identify examples of:

- a) any assistance which you consider could not reasonably be regarded as unlawful under the current common law position in Scotland?
  - b) any assistance which you consider would be unlikely to be criminal in Scotland under the common law?
  - c) any assistance which you consider would be likely to be criminal in Scotland under the common law?
  - d) any assistance whose status you would regard as particularly uncertain under the common law?"
8. Given the degree of legal uncertainty here, I do not think I can usefully list types of assistance under the headings (a)-(d) in this question. In answering this question as best I can, it is helpful to adopt the categorisation of types of assistance in suicide which Professor Ferguson offered in her 1998 article (cited earlier) on the subject ((1998) 2 Edin LR 289 at 291):

“(1) a positive, direct act, immediately connected with the victim’s death;  
(2) the provision of the means of suicide;  
(3) the provision of information or advice;  
(4) an omission to act: failure of the accused to prevent the victim from committing (or attempting to commit) suicide)”

9. Given developments since Professor Ferguson’s article was published, the following category should be added:

“(5) assisting with travel abroad, or arrangements for travel abroad, to commit suicide”

***A positive, direct act, immediately connected with the death of another person***

10. Assuming such an act (such as the administration of a drug, or suffocation) was intended to cause death, and did so, it would almost certainly amount to murder in Scots law. (The question of whether suicide is criminal in itself is irrelevant here.) In practice, if the act were carried out at the deceased’s request, there is a strong possibility that Crown Office would exercise its discretion to prosecute for culpable homicide rather than murder.

***The provision of the means of suicide***

11. In *Khalid v HM Advocate* 1984 JC 23, the High Court held that a person who supplied solvents to children knowing they intended to abuse them was responsible for the actions of the children in doing so, and therefore guilty of a form of culpable and reckless conduct. The principle was subsequently extended to supply to adults (*Ulhaq v HM Advocate* 1991 SLT 614). In due course, this led to prosecutions for culpable homicide in cases where drugs had been supplied to persons who took them and died. This practice was challenged in the cases of *MacAngus v HM Advocate*; *Kane v HM Advocate* 2009 SLT 137. There, it was noted that the House of

Lords (in *R v Kennedy (No 2)* [2008] 1 AC 269) had ruled that, in English law, where a fully-informed and responsible adult had chosen to take a drug supplied to them, the supplier could not be held to have caused the consequences which followed from their taking the drug.

12. The High Court of Justiciary was not, however, prepared to make such a categorical statement. After reviewing the Scottish cases, the court concluded (at paras 42 and 48 of *MacAngus* and *Kane*):

“These Scottish authorities tend to suggest that the actions (including in some cases deliberate actions) of victims, among them victims of full age and without mental disability, do not necessarily break the chain of causation between the actings of the accused and the victim's death. What appears to be required is a judgment (essentially one of fact) as to whether, in the whole circumstances, including the inter-personal relations of the victim and the accused and the latter's conduct, that conduct can be said to be an immediate and direct cause of the death...

The adult status and the deliberate conduct of a person to whom a controlled drug is recklessly supplied by another will be important, in some cases crucial, factors in determining whether that other's act was or was not, for the purposes of criminal responsibility, a cause of any death which follows upon ingestion of the drug. But a deliberate decision by the victim of the reckless conduct to ingest the drug will not necessarily break the chain of causation.”

13. The “not necessarily” conclusion reached by the High Court gives little concrete guidance on how the law would approach the facts of any future case. It at least leaves open the possibility that provision of the means of suicide would be regarded as the legal cause of death. If the provider knew the purpose for which the means were provided, they would almost certainly have the necessary *mens rea* for murder, or at least culpable homicide. (As with category (1), discretion in prosecution might well be exercised by Crown Office.)
14. As with category (1), this conclusion does not itself depend on the question of whether suicide is itself criminal. However, if the courts held that a decision to make use of the means of suicide *did* break the chain of causation, it would be open to the prosecution to argue that the supplier was nevertheless guilty of murder (or culpable homicide) art and part, on the basis that they had supplied the means for the commission of a criminal act.

***The provision of information or advice***

15. If suicide is not a criminal offence, it is very unlikely that such actions could result in criminal liability. It has been said that “Where A merely encourages B to commit suicide there can be little doubt that A is not the cause of death.” (Gordon, *Criminal Law*, para 4.53.)
16. If suicide is itself a criminal offence, then the possibility of art and part liability arises. Even here, however, advice in general terms is not normally

regarded as sufficient for liability. In *HM Advocate v Johnstone* 1926 JC 89, it was held that a woman who passed on the name of an abortionist did not become criminally liable for the abortion which subsequently took place. This, it was suggested, could not amount to the “actual participation in the illegal act” required for liability. However, more extensive advice and advocacy might be held in law to amount to participation (cf the abortion case of *HM Advocate v Semple* 1937 JC 41, although that case also involved the provision of means).

***An omission to act***

17. There is an extensive discussion of this in Professor Ferguson’s article (at 309-313). Broadly speaking, while there is a lack of Scottish authority, the law of omissions holds that in particular circumstances one person (A) may have a duty to prevent harm coming to another (B). This duty is most clearly recognised where there is a dependent relationship, such as that between a parent (A) and a child (B). It may also be recognised between spouses or partners, but different courts in different jurisdictions have reached different conclusions in such cases. Any question of liability here is highly speculative, and there would seem little basis for an argument that a person who failed to intervene in another’s decision to commit suicide should incur criminal liability as a result. The argument could only arise with any force where A and B were in a relationship of dependence and A knew that B’s decision was not in fact free and voluntary.

***Assisting with travel abroad, or arrangements for travel abroad***

18. This issue arose in the *Purdy* case. When that case reached the House of Lords, it was suggested that, were Ms Purdy’s husband to assist her in travelling abroad to commit suicide, any offence would be outwith the jurisdiction of the English courts. If that had been correct, her husband would not have been at risk of prosecution in England, and the absence of prosecutorial guidelines applicable to assisted suicide would have been irrelevant in his case. The House of Lords, however, held that it was at least arguable that the English courts would have jurisdiction over such a case.

19. In the *Juridical Review* article discussing *Purdy* which I mentioned earlier in this note, the authors state as follows:

“The current position is that Scots law does not criminalise accompanying a person on a trip, irrespective of the purpose of that person’s journey, even if they will thereafter take part in activities that are legal in the host state but not within Scotland.” (2009 JR 265 at 280.)

20. The authors, however, cite no authority for that statement, and it goes further than can safely be supported on the basis of the relevant legal authorities. Jurisdiction in Scotland requires a “territorial connection” to Scotland (Gordon’s *Criminal Law*, para 3.44). The High Court has held that the Scottish courts are entitled to take jurisdiction over a criminal scheme where steps to complete that scheme are taken both in Scotland and in another jurisdiction (see *Laird v HM Advocate* 1985 JC 37, a case which

involved a fraudulent scheme which took place in Scotland and England, with the payment which was obtained by fraud being made in England).

21. If A assists B with travelling abroad for the purposes of committing suicide – or making arrangements to do so – it would be open to A to argue that the Scottish courts should not assert jurisdiction. In support of that argument, it might be suggested that the legality of suicide in that other jurisdiction would provide a reason of “international comity” for declining to exercise jurisdiction (*cf R v Smith (Wallace Duncan) (No 4)* [2004] QB 1418). The legal position cannot, however, be stated with any certainty.
22. Again, the clarity of the position here is affected by the uncertainty over whether or not suicide amounts to a crime in itself. If it is an offence, it would not be difficult for the courts to conclude that assistance with travel (or arrangements for travel) amounted to sufficient participation to render A liable art and part for murder or culpable homicide. If suicide is *not* an offence, it might be argued that A’s actions could not properly be regarded as having caused B’s death. However, the approach taken in *MacAngus* and *Kane* to the causation of another person’s actions mean that this point is itself uncertain. The courts might well be willing to conclude that A’s actions were a cause of B’s death, particularly if B would otherwise have been unable to travel abroad and commit suicide.

### Question 2

23. You have asked me to “comment on which factors you consider would be important in determining whether conduct was lawful or unlawful within the existing common law framework”.
24. Given the uncertainty of the law, there is nothing I can usefully add here to the comments I have already made. I have no doubt that, in deciding whether to prosecute, Crown Office would take into account factors broadly similar to those listed in the Crown Prosecution’s Service *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide*. That decision is, however, one of whether a prosecution would be in the public interest. Crown Office would doubtless also take into account the uncertainty of the legal position in making any decision.

### Question 3

25. You have asked me “[i]n what way(s) and to what extent would the enactment of the Assisted Suicide (Scotland) Bill in its present form resolve the lack of clarity in the existing law. In what way(s) and to what extent would the law remain unclear after the passing of the Bill, if it were to be passed?”
26. The Bill makes no attempt to set out a general statement of when assisting suicide is criminal. It simply sets out circumstances in which it would *not* be criminal. It would clarify the law only to the narrow extent of stating that assistance in the circumstances set out in section 3 of the Bill would not be unlawful. However, the Bill would provide a clear route which persons wishing to commit assisted suicide would be able to follow. It would allow those persons who met the criteria specified in the legislation to be



confident that they were acting lawfully. It would therefore, in practical effect, significantly alleviate the current lack of clarity. Any remaining uncertainty as to the scope of the law, would not be a defect in the legislation itself. It would, instead, be a defect in the general law.

27. I note that in its report to the Health and Sport Committee, the Justice Committee noted that the approach taken by the Bill was unusual, in “defining what is not a crime rather than what is a crime” (para 33). Such an approach is, however, not unprecedented and should not itself be regarded as problematic. It was, prior to the Sexual Offences (Scotland) Act 2009, the approach taken in Scots law to homosexuality, where legislation (latterly section 13 of the Criminal Law (Consolidation) (Scotland) Act 1995) provided that male homosexual conduct would *not* be criminal provided that it took place in private between consenting adults.
28. That approach was objectionable, because it implied that homosexual conduct was presumptively wrong subject to a legal exception, whereas heterosexual conduct was presumptively legitimate subject to such exceptions as were set out by law. It drew an unsupportable distinction on the ground of sexuality. However, such an approach is not objectionable in the present context. If assisted suicide is to be made lawful, it is quite right that the law should maintain the general position that actions which bring about the death of another person are wrong, while providing for an exception in the case of assisted suicide carried out in accordance with suitable safeguards.

#### Question 4

29. You have asked me whether, if the Bill were enacted, “how detrimental would it be to the effectiveness of the legislation if some legal uncertainty remains after the passing of the legislation?”
30. If the Bill is enacted, it may be the case that there are persons who wish to commit assisted suicide, are unable to comply with the requirements of the legislation, but take steps to do so nevertheless. The Bill is not designed to clarify the question of criminal liability in such cases, and it would not do so, except insofar as it might influence the courts’ approach to any case which fell outwith the terms of the Bill. It should, in principle, also reduce the number of cases in which such uncertainty could arise. However, any remaining uncertainty will not affect the position of those who act within the terms of the legislation, and this uncertainty will not itself impair the effectiveness of the legislation.

#### Question 5

31. You have asked me whether “there are any possible alternative approaches to clarifying the Scots criminal law position in relation to assisted suicide, other than legislating to permit assisted suicide in certain circumstances and if certain requirements are observed (as the present Bill seeks to do)?”
32. The most obvious approach would be to legislate (a) to make it clear beyond doubt that suicide is not itself a criminal offence in Scots law and

(b) to create a criminal offence of criminal liability for complicity in another's suicide, similar to that found in s 2(1) of the Suicide Act 1961 (as amended by s 59 of the Coroners and Justice Act 2009).

33. It should not be thought, however, that the provisions of s 2(1) of the 1961 Act provide a ready-made model for reform. In principle, any offence which makes it criminal to assist someone to do something which *they* can lawfully do is problematic. Moreover, the current s 2(1) can be criticised for encompassing the possibility of prosecution for encouraging or assisting persons unknown, and leaving open the question of jurisdiction in relation to a suicide which takes place abroad. Any reform should follow consideration by the Scottish Law Commission or a suitably constituted expert group.
34. Such a reform would clarify the position of individuals who assist close relatives or friends to commit suicide. It would not, of course, fulfil the aim of the Bill, which is to provide a mechanism for those who wish to commit suicide to do so under certain conditions.
35. Subject to what I say in response to question 6, I do not believe that the legal position can be clarified other than by legislation.

#### Question 6

36. You have asked me whether "there is anything you wish to add concerning the clarity of the existing law relating to assisted suicide, either in general terms or in relation to the Bill?"
37. In *Purdy*, the House of Lords held that the absence of a specific prosecutorial policy addressing assisted suicide meant that the Director of Public Prosecutions was acting incompatibly with article 8(2) of the European Convention on Human Rights. This was because the offence of aiding and abetting the suicide of another (as it then was) was so special in nature that the general *Code for Crown Prosecutors* did not provide sufficient guidance so as to make the consequences of aiding or abetting suicide foreseeable. The general prosecutorial criteria set out in the *Code* were (as the DPP had admitted in dealing with the Daniel James case) of little or no use in making decisions in such cases.
38. In the aftermath of *Purdy*, the then Lord Advocate noted that the English offence had no Scottish counterpart, and so chose not to take steps to issue a policy similar to that promulgated by the DPP. That approach was wrong. It remains wrong. The problem was that the very special circumstances in which assisting suicide occurs are such that the general prosecutorial criteria could not provide appropriate guidance in such cases. (To the extent that the problem in *Purdy* was based on the fact that suicide was not itself criminal, as the DPP had suggested in the James case, it will be noted from what I have said earlier that this may also be the case in Scotland.) The general criteria set out in the *Scottish Prosecution Code* are similarly inapt to deal with such cases. Following the decision in *Purdy*, I do not see how the absence of prosecutorial guidance on assisted suicide in Scotland can be regarded as compatible with the Lord Advocate's obligations under the European Convention on Human Rights.

I have already made this point in the article which I cited earlier in this note ((2010) 14 Edin LR 295).

**James Chalmers  
Regius Professor of Law at the University of Glasgow  
9 February 2015**

**Assisted Suicide (Scotland) Bill**

**Professor Pamela R Ferguson, Professor of Scots Law, University of  
Dundee<sup>1</sup>**

**Question Paper: The Position under Existing Scots Criminal Law**

**Introduction**

The Question Paper asked respondents to distinguish between assistance (a) which could not reasonably be regarded as unlawful, (b) which was unlikely to be criminal, (c) which was likely to be criminal and (d) whose status was particularly uncertain under the current common law. In my view, the current law is too uncertain to offer much meaningful categorisation in this way. A distinction also needs to be drawn between the legal position in theory, and its operation in practice.

Assistance in suicide comprises a range of behaviours, including:

- 1) positive, direct acts, immediately connected with the subsequent death
- 2) the provision of the means of committing suicide
- 3) the provision of information and advice
- 4) an omission to act: failure by one person to prevent another person from committing (or attempting to commit) suicide.

The distinction between (1) and (2) above is of course difficult to draw in practice. Where A hands B a phial of poison, which B immediately swallows, is this merely the provision of the means of suicide? Or a positive direct act, immediately connected to B's death? I have defined 'assistance' as falling into category (1) only where there is no need for an action on the part of B, e.g. where A injects a deadly substance into B. This seems to correspond with the approach taken in the Bill, which focuses primarily on actions within category (2).

Common law crimes comprise at least two elements: (i) some prohibited conduct and (ii) a legally blameworthy state of mind. Since neither 'attempting suicide' nor 'assisting suicide' are recognised crimes in Scottish law, a person who assists in a successful suicide attempt could be charged with murder or culpable homicide. If the attempt fails, then other common law crimes such as 'causing real injury', 'culpable and reckless injury', or 'reckless endangerment' could be charged. This response focusses on cases in which the assistance has resulted in death. In relation to the 'prohibited conduct', for both murder and culpable homicide this is defined as causing the death of the patient.<sup>2</sup> The two crimes are distinguished by the state of mind of the assister. A person

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<sup>1</sup> This response draws on my paper: "Killing 'without getting into trouble'? Assisted Suicide and Scots Criminal Law" (1988) 2 *Edinburgh Law Review* 288-314. I have updated the law, as necessary.

<sup>2</sup> I have avoided using the term 'victim' since the Bill deals with cases in which the patient is requesting death, and consents to the actions of the 'assister'.

who intends to kill is generally treated as having the requisite state of mind for a charge of murder. This is discussed further, below.

In determining which behaviours could or might be criminal, much depends on the attitude taken by Crown Office, and thereafter by the courts, to the issue of 'causation'. This is often treated as a matter of public policy: in what circumstances *ought* A to be said to have caused, and therefore to be held responsible for, B's death? It seems unlikely that the provision of general advice, such as dissemination of information about the types and amounts of medication required for a fatal dose, would be regarded as sufficiently proximate to a patient's death to amount to causing that death. It is less clear whether this approach would apply were the same information conveyed to a person who had revealed in advance that they intended to use the information to commit suicide. There could perhaps be civil liability for a doctor who gives advice on lethal drugs to a depressed patient, knowing the patient's intentions.

The criminal law draws a distinction between positive acts, on the one hand, and omissions to act, on the other. It is generally not a crime to allow someone to die through failing to act, unless the person omitting to act is under a legal duty of care towards the other person. Healthcare professionals are, of course, under a legal duty to treat their patients. If, however, a particular treatment becomes futile, a doctor can decide to cease the treatment - that is, to omit to continue it, and this is unlikely to incur either criminal or civil liability.<sup>3</sup>

Behaviour falling into my first category - a positive, direct act, immediately connected with the patient's death, - would be likely to be criminal under the theory of the current law. It is more difficult to determine whether this would amount to murder or culpable homicide. In a paper I wrote on assisted suicide in 1998,<sup>4</sup> I suggested that if, for example, a doctor were to administer a lethal injection to a patient, intending to cause death, this was likely to fulfil the requirements for a murder charge: the doctor has caused the death of another human being, and has done so intending to kill that person. The fact that the doctor had a good motive<sup>5</sup> (to alleviate suffering), that the patient would have died shortly in any event, and that the patient consented to being killed<sup>6</sup> were all, strictly speaking, irrelevant so far as the criminal law was concerned. In the case of *Drury v HM Advocate* (2001), however, Lord Justice-General

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<sup>3</sup> In *Law Hospital NHS Trust v Lord Advocate* 1996 SC 301 'treatment' was defined to include feeding and hydration where the patient was in a persistent vegetative state.

<sup>4</sup> See note 1, above.

<sup>5</sup> *HM Advocate v Rutherford* 1947 JC 1 at 6: "What the law looks for is, not the motive at the back of a man's mind, but the intention, the intent with which he acts."

<sup>6</sup> *HM Advocate v Rutherford* 1947 JC 1 at 5: "...the crime does not cease to be murder merely because the victim consented, or even urged the assailant to strike the fatal blow."

Roger redefined the legally blameworthy state of mind required for murder such that there must be not merely an intent to kill, but a 'wicked intent to kill'. It could therefore be suggested that a person who kills from a compassionate motive lacks the 'wickedness' now required for a charge of murder.<sup>7</sup>

If the assistance to die was performed by a relative of the patient, rather than a medical practitioner, then the Crown could accept a plea of guilty to culpable homicide, rather than murder, on the grounds that the relative was suffering from 'diminished responsibility' due to the stress caused by watching a loved-one suffer. It seems unlikely that a healthcare professional would be able to rely on this as a mitigating factor.

I have used the phrases 'under the theory of the current law', and 'strictly speaking' (above) since this does not necessarily reflect practice. Pragmatically, culpable homicide may be said to be any killing where the Crown Office is satisfied that murder is not the appropriate charge. *Gordon's Criminal Law* suggests that 'it is thought that ... those who commit euthanasia would be charged only with culpable homicide in Scotland', and attributes this to 'the absence of malice' on the part of the accused towards the 'victim', in such cases.<sup>8</sup> This suggestion may well be correct. In 1996, (well before *Drury* injected 'wicked' into the definition of 'intent to kill') Paul Brady fed his brother, James, tranquillizers and alcohol and then smothered him. James had been suffering from Huntington's Chorea and had asked Paul to help him die. The Crown accepted Paul Brady's offer to plead guilty to culpable homicide.<sup>9</sup> In admonishing Paul, the judge noted that the accused had brought his brother's life to an end at the latter's 'own earnest and prolonged heartfelt request'.<sup>10</sup> It seems, therefore, that the fact that a victim has requested assistance to die may make it more likely that the accused will be charged with culpable homicide than with murder, and may be reflected in a lighter sentence, but much depends on the approach of the Crown Office, and that of the trial judge. This is very much a grey area.

Where the accused person is a healthcare professional, the principle of 'double effect' may offer a defence. In the English law case of *R v Adams*<sup>11</sup> Devlin J. stated that if a doctor can show that his or her primary intention was to alleviate the patient's pain, rather than to kill the patient, then the administration of potentially lethal drugs will not be criminal. This applies even where the doctor realises that a likely consequence of killing the pain is that this will result in the death of the patient. It is likely that this principle also

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<sup>7</sup> See Pamela R. Ferguson and C. McDiarmid, *Scots Criminal Law: A Critical Analysis* (EUP, 2014, 2nd edn) at para 9.16.4.

<sup>8</sup> *Gordon's Criminal Law* (3<sup>rd</sup> edn, 2000, edited by M.G.A. Christie, Vol I) para 7.07.

<sup>9</sup> The case is unreported, but see E Clouston, "Man who kills incurable brother freed", *The Guardian*, 15 October 1996. K McVeigh, "Message of hope in ruling by judge", *The Scotsman*, 15 October 1996.

<sup>10</sup> *The Guardian*, note 8 above.

<sup>11</sup> [1957] Crim LR 365.

operates in Scottish law. In an earlier edition of *Gordon's Criminal Law*, it was suggested that in practice criminal liability will not result for

'the doctor who prescribes pain-killing drugs in the knowledge that they will shorten life, provided they are given with the intention of easing pain and not as a measure of euthanasia. This exception has no legal basis but is an example of the law turning a blind eye for sympathetic reasons. It does not extend to acts intended to accelerate death.'<sup>12</sup>

The doctrine of double-effect does not seem to be discussed in the latest edition of *Gordon*. However, even where there is no 'double effect', the Crown may decide that prosecution is not in the public interest. This seems to have occurred in the case of a consultant neonatologist at Aberdeen Maternity Hospital who admitted to the General Medical Council in 2007 that he had injected two dying babies with a paralysing drug, hastening their deaths. One child had been given 23 times the normal dose of muscle relaxant. No prosecution was taken.<sup>13</sup>

There is also some uncertainty over whether Scottish criminal law treats administration of harmful substances differently from their mere supply. Cases such as that of *Khaliq v HM Advocate*<sup>14</sup> show that in some circumstances the appeal court does not differentiate between the two.<sup>15</sup> The accused in that case were charged with injuring children by supplying them with 'glue-sniffing kits' (glue decanted into plastic bags). Although these facts are very different from an assisted suicide, *Khaliq* does illustrate the courts' approach to causation in 'supply' cases. According to Lord Justice-General Emslie it was

'not fatal to the relevancy of [the] charge ... that a voluntary act on the part of the recipients [of the harmful substance] ... was required to produce the injurious consequences which they are alleged to have suffered. The causal link is not, of necessity, broken by that circumstance.'<sup>16</sup>

As previously described, both murder and culpable homicide are 'result crimes' - that is, the prosecution must prove a causal link between the acts of the accused and the patient's death: did the accused's behaviour cause the death? If a doctor supplies a patient with lethal drugs, in the knowledge that

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<sup>12</sup> G.H. Gordon, *Criminal Law*, (2nd edn, 1978), p 728, n 14.

<sup>13</sup> The case is discussed further in Pamela R. Ferguson and C. McDiarmid, *Scots Criminal Law: A Critical Analysis* (2nd edn, 2014) at para 6.10.2.

<sup>14</sup> 1984 JC 23.

<sup>15</sup> 1984 JC 23 at 33.

<sup>16</sup> 1984 JC 23 at 33. That the recipients of the noxious substance were children was not material to the ruling in *Khaliq*: see *Ulhaq v HM Advocate* 1991 SLT 614; *Lord Advocate's Reference (No 1 of 1994)* 1995 SLT 248, *MacAngus and Kane v HM Advocate* 2009 SLT 137: "... a deliberate decision by the victim... to ingest the drug will not necessarily break the chain of causation." (at p.151, para 48).

the patient intends to use these drugs to commit suicide, can we say that the doctor has 'caused' the death? It may be that the courts would treat the patient's decision to swallow the drugs as a '*novus actus interveniens*'- a new, supervening act which breaks the chain of causation between the act of supply and the death. Whether the patient's own act in swallowing the drugs, or the assister's supply of the drugs, is treated as the cause of death is a public policy decision. Examination of the Scottish case law suggests that where the High Court disapproves of an accused person's behaviour, it is not generally disposed to allow actions of a 'victim' to interrupt the causal link between that behaviour and harm to the victim. Another example is the case of *McDonald v HM Advocate*,<sup>17</sup> in which the two accused had badly assaulted the victim and left him in a locked flat, without a phone. The victim, who was under the influence of amphetamines, then attempted to leave the flat – which was on the third floor – by means of climbing out of the window. He fell to his death. It might have been expected that the victim's behaviour would be treated as a '*novus actus*', breaking the causal link between the assault by the accused and the death. However, the appeal court found that the issue of causation had been properly left to the jury, which had convicted the accused of culpable homicide. This illustrates that even voluntary and (arguably) unreasonable behaviour on the part of a 'victim' will not necessarily be treated as the cause of a 'victim's' death.

**1. Please comment on which factors you consider would be important in determining whether conduct was lawful or unlawful within the existing common law framework?**

See above: while motive is in theory a factor to be considered in sentencing, but is irrelevant to criminal liability, in practice a compassionate motive may make it more likely that the Crown will accept a plea of guilty to culpable homicide, rather than prosecute for murder.

**2. In what way(s) and to what extent would the enactment of the Assisted Suicide (Scotland) Bill in its present form resolve the lack of clarity in the existing law? In what way(s) and to what extent would the law remain unclear after the passing of the Bill, if it were to be passed?**

The enactment of the Bill would make it clear that the forms of assistance provided for in the legislation would not be criminal – that is, supplying, but not administering, the means for suicide, so long as this takes place within the parameters of the legislation. It would remain unclear whether actual administration of the drugs to the patient is murder or culpable homicide - or no crime. The Bill provides in s. 1(3) that a court can find that a person who has assisted another to commit suicide has not committed a crime, even where the assistance has not complied with the legislation. Equally, however, a court could hold that more direct forms of assistance are murder or culpable homicide. But since the current common law is unclear, this confusion will remain. This could be clarified by providing in the Bill that where a patient

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<sup>17</sup> 2007 SCCR 10.



becomes physically unable to self-administer the medication, and someone else does so, this would be charged as culpable homicide. Alternatively, actual administration could also be de-criminalised, other than in cases in which there is reason to suspect that the patient had changed his or her mind about wanting to die at that time, and in that manner.

**3. If the Bill was enacted, how detrimental would it be to the effectiveness of the legislation if some legal uncertainty remains after the passing of the legislation?**

This is difficult to predict. It may be that the mechanisms provided by the Bill will cover the majority of cases of assisted suicide in future. But there will inevitably be cases in which a patient becomes too ill to be able to self-administer the drugs, and those assisting such patients to die (whether relatives or licensed facilitators) remain in a vulnerable position, so far as their exposure to criminal liability is concerned.

**4. Are there any possible alternative approaches to clarifying the Scots criminal law position in relation to assisted suicide, other than legislating to permit assisted suicide in certain circumstances and if certain requirements are observed (as the present Bill seeks to do)? For any alternatives you identify, please comment briefly on whether you consider them to have any significant advantages or disadvantages, from a criminal law perspective, in comparison with (i) the current law and (ii) the proposals in the Bill.**

See answer to question 3, above. It could be argued that the Bill needs to go further to clarify the legality (or otherwise) of assistance not currently covered by the Bill's provisions. Section 37 of the *Draft Criminal Code for Scotland* offers an amended definition of the crime of murder, to make explicit that the doctrine of double effect provides a defence:

**37 Murder**

(1) A person who causes the death of another person with the intention of causing such a death, or with callous recklessness as to whether such a death is caused, is guilty of the offence of murder.

(2) ... a registered medical practitioner, or a person acting under the direction of such a practitioner, who, acting with the consent of a patient or with lawful authority, does anything reasonably and in good faith with the primary purpose of relieving the patient's pain or discomfort is not regarded as intending to cause the death of the patient merely because the practitioner or other person foresees that the death is certain or almost certain to occur earlier than it otherwise would.

**5. If there is anything you wish to add concerning the clarity of the existing law relating to assisted suicide, either in general terms or in relation to the Bill?**

I have nothing to add regarding clarity.

On a separate note, I believe that 16 is too young an age for a person to be a licensed facilitator.

**Professor Pamela R Ferguson**

<p>Agenda item 2</p>  <p>17 February 2015</p>		<p>HS/S4/15/5/3</p>
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## Health and Sport Committee

### Assisted dying and suicide in other jurisdictions

After a recent evidence session, Members of the Committee asked for further information on the countries and jurisdictions that permit assisted dying. Specifically, Members asked for:

- Information on the numbers of people using the assisted dying laws
- Information on the rates of other types of suicide in these places
- A breakdown of the suicide statistics for Scotland by age and gender

The following paper details background and statistics on assisted dying laws in Belgium, the Netherlands and Oregon. These particular areas were chosen because they are most commonly referenced in the debate and also because they are the areas where information is most readily available.

Members should use caution in drawing conclusions from trends in the total number of people whose death is hastened using these laws. This is because they are presented in isolation and do not take account of changes in other legally permissible practices which may hasten death, for example, palliative sedation.

Members should also bear in mind the differences in the laws in each of these places. For example, Oregon does not permit euthanasia but Belgium and the Netherlands do. Each jurisdiction also has different reporting requirements, which may have an influence on reported numbers.

### Assisted dying in other countries

#### Belgium

In Belgium, the Euthanasia Act 2002 allows physicians to perform euthanasia (also understood as ‘termination of life on request’). Assisted suicide is not explicitly covered, although the Federal Control and Evaluation Commission (FCEC) – Belgium’s oversight body– has accepted that cases of assisted suicide fall under the law.

Broadly speaking, euthanasia is permissible under three key conditions: 1.) the patient is competent at the time of the request, 2.) the request is voluntary and consistent, and 3.) the patient is ‘in a medically futile condition of constant

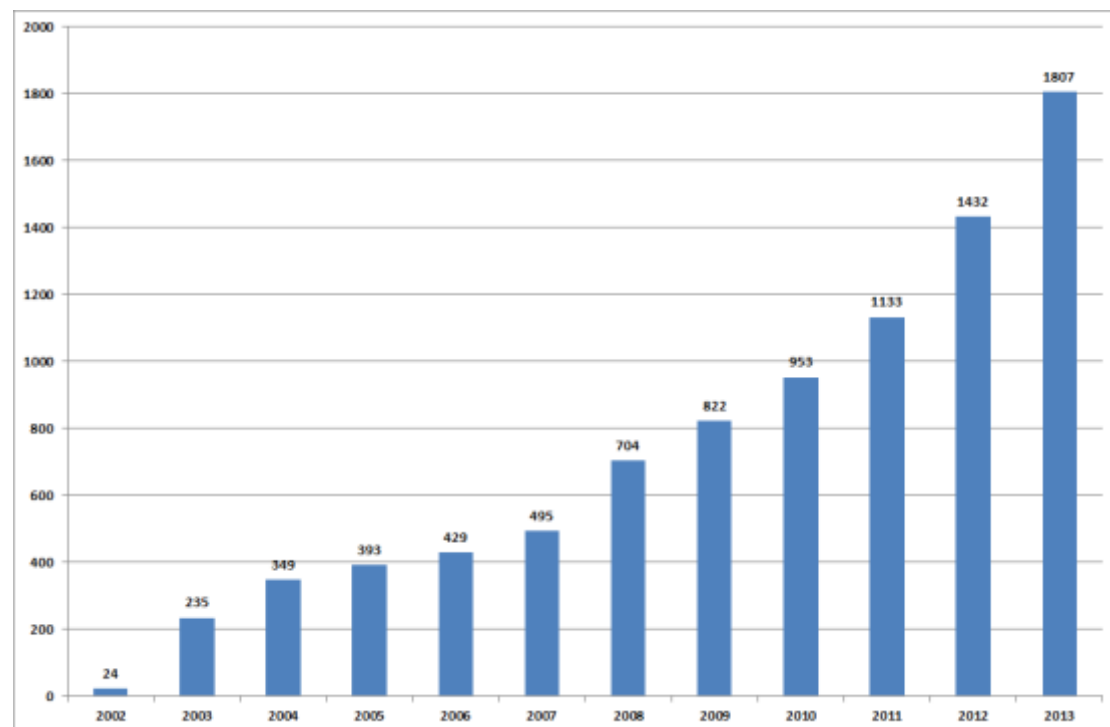
and unbearable physical or mental suffering that cannot be alleviated resulting from a serious and incurable disorder caused by an illness or accident’.

Euthanasia was initially restricted to patients over the age of 18 and for minors over 15 who had been ‘legally emancipated’. However, recently the law was extended to all ages, although children would require the approval of their parents and counselling by doctors and a psychologist/psychiatrist.

All cases of euthanasia must be reported to the FCEC, which monitors compliance with the law and can refer deaths which do not comply with the statutory conditions to the local state prosecutors. It also produces an annual report<sup>1</sup>, which provides more information on the cases of euthanasia that have occurred during the year. There is no penalty for not reporting a death and the advice of the National Order of Physicians (regulator of the Belgian medical profession) is not to disclose on the death certificate the fact that a death was caused by euthanasia<sup>2</sup>. This is likely to give rise to under-reporting and research estimated the reporting rate in Belgium in 2007 to be 52.8%<sup>3</sup>.

The most recent report provides the following figures on the number of reported cases of euthanasia between 2002 and 2013:

**Figure 1: Number of reported cases of euthanasia in Belgium, 2002-2013**



<sup>1</sup> Commission Federale de Controle (2014) [Sixieme Rapport aux Chambres Legislative \(Annees 2012-2013\)](#)

<sup>2</sup> Lewis, P and Black, I. (2013) Reporting and scrutiny of reported cases in four jurisdictions where assisted dying is lawful: A review of the evidence in the Netherlands, Belgium, Oregon and Switzerland. *Medical Law International*, Vol 13(4): 221-239.

<sup>3</sup> Ibid

The annual report, details that deaths from euthanasia reported during 2002-2013 have averaged about 1.5% of all deaths, although this has steadily increased over the years (1.3% in 2012 and 1.7% in 2013). According to Dr Benoit Beuselinck (a Belgian oncologist) between 2002 and 2013, deaths from euthanasia increased from 0.4% to 1.7% of all deaths in Belgium<sup>4</sup>.

The majority of euthanasia cases in 2012 and 2013 involved people with a diagnosis of cancer (73%). The next most common diagnostic category was neurological disorders (6.2%).

## **Netherlands**

In the Netherlands, both euthanasia (understood as termination of life on request) and assisted suicide are legally permitted if performed by physicians in accordance with statutory 'due care criteria' set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. These criteria are that physicians must:

- a) be satisfied that the patient has made a voluntary and carefully considered request;
- b) be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement;
- c) have informed the patient of his or her situation and further prognosis;
- d) have come to the conclusion, together with the patient, that there is no other reasonable alternative;
- e) consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;
- f) have exercised due medical care and attention in terminating the patient's life or assisting in his or her suicide.

The law can be used by those over 18 and patients between the ages of 12 and 18 who are 'capable of making a reasonable appraisal' of their own interests. The parent or guardian of those between 16 and 18 must be consulted but do not have a right of veto. Patients between 12 and 16 must also have the consent of their parent or guardian.

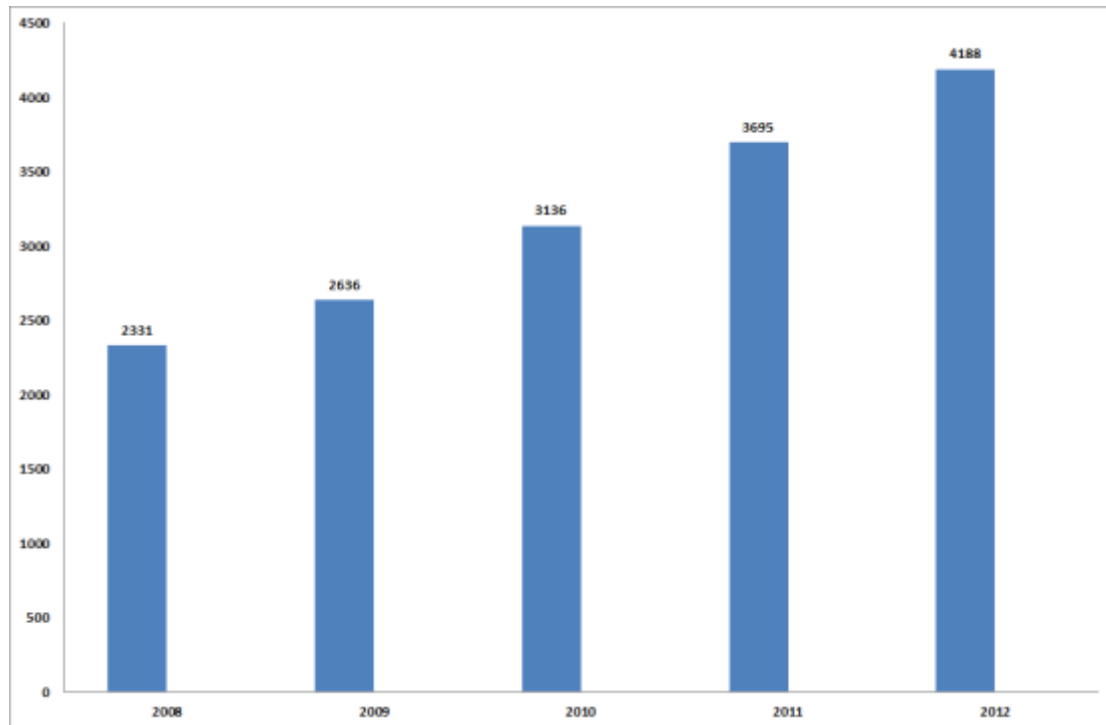
When a physician has terminated the life of a patient on request, or assisted in his suicide, they must notify the municipal pathologist. When doing so, they submit a detailed report showing that they have complied with the due care criteria. The pathologist then notifies the regional 'Euthanasia Review Committee' of each assisted death and the Committee may investigate further to ensure that the due care criteria have been met. Each Committee consists of three members; a lawyer (chair), a physician and an ethicist. It is the physician's responsibility to convince the Committee that all of the due care criteria have been met. If it concludes that they have not been, the Committee refers the matter for further investigation and possible prosecution and/or professional disciplinary action.

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<sup>4</sup> Conference Report from "[Euthanasia and Assisted Suicide: Lessons from Belgium](#)"

The following graph shows the total number of cases of euthanasia and assisted suicide in the Netherlands since 2008. This is taken from the latest annual report<sup>5</sup> of the Regional Euthanasia Review Committees.

**Figure 2: Number of reported cases of euthanasia and assisted suicide in the Netherlands, 2008-2012**



In 2012, 94.7% (n=3965) of these deaths were from euthanasia, 4.4% (n=185) were from assisted suicide and 0.9% (n=38) were a combination of both. The report does not detail what portion of all deaths these assisted deaths accounted for.

While the graph shows a steady increase in cases, Lewis and Black<sup>6</sup> highlight that more deaths came to be reported as the control system became more established. The latest estimate on the Dutch reporting rate was that 77% of cases were reported in 2010<sup>7</sup>.

As in Belgium, the most common illnesses among those using the laws were cancer (86%) and neurological disorders (6.8%).

<sup>5</sup> Regional Euthanasia Review Committee (2012) [Annual Report 2012](#).

<sup>6</sup> Lewis, P and Black, I. (2013) Reporting and scrutiny of reported cases in four jurisdictions where assisted dying is lawful: A review of the evidence in the Netherlands, Belgium, Oregon and Switzerland. *Medical Law International*, Vol 13(4): 221-239.

<sup>7</sup> Ibid

## Oregon

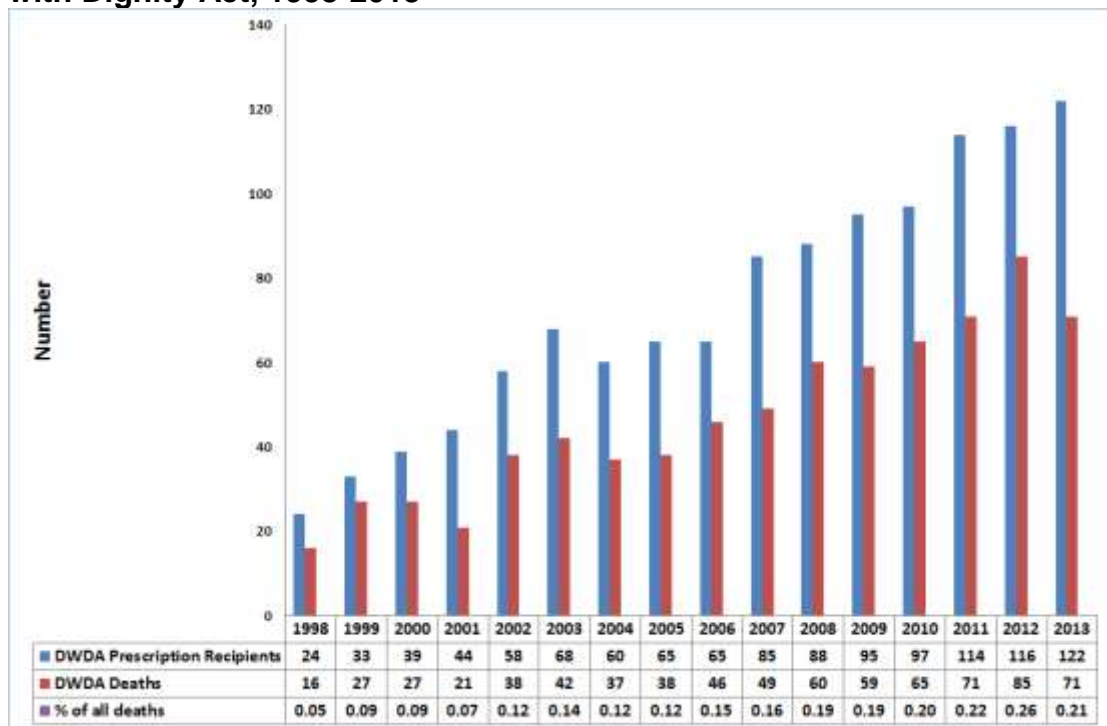
In Oregon, the Death with Dignity Act 1994 permits physician-assisted suicide in one form: the provision of a prescription for lethal medication, to be self-administered by the patient. Neither euthanasia, nor any other form of physician-assisted suicide is permitted.

The patient must be over 18 and suffering from a terminal disease, defined as ‘an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months’. There is no additional requirement relating to the patient’s experience of the disease or any minimum level of suffering.

A physician acting under the Act must report each prescription written, as well as each death resulting from ingestion of the prescribed substance. There is no penalty for not reporting a prescription or a death.

Figure 3 shows the number of prescriptions written under the Act, the total number of reported deaths and what proportion of all deaths they constitute between 1998 and 2013.

**Figure 3: Prescriptions dispensed and deaths under the Oregon Dying with Dignity Act, 1998-2013**



Source: Oregon Health Authority<sup>8 9</sup>

Figure 3 shows that the number of deaths under the Act in 1998 was 16, rising to 71 in 2013. These accounted for 0.05% of all deaths in Oregon in

<sup>8</sup> Oregon Health Authority (2013) [Oregon Vital Statistics 2013](#)

<sup>9</sup> Oregon Health Authority (2014) [Death with Dignity Act Annual Report 2013](#)

1998 and 0.21% of all deaths in 2013. There has been no estimate of the prevalence of unreported deaths.

As in Belgium and the Netherlands, cases of assisted dying in Oregon are most common in people with cancer (64.8% in 2013) and the neurological disorder Amyotrophic Lateral Sclerosis (7% in 2013).

## Suicide

The following graph shows trends in the rates of suicide in Belgium, the Netherlands, Oregon and Scotland. Please note that the rates for Belgium, the Netherlands and Scotland are all age standardised to the European population while the Oregon rate is unadjusted.

Data for Belgium was incomplete but for the years it was available it shows that the Belgian rate of suicide was generally higher than the other three areas. The next highest rate was in Oregon, followed by Scotland and lastly the Netherlands.

**Figure 4: Suicides per 100,000 population in Belgium, the Netherlands, Oregon and Scotland 1998-2010**



Source: [Scotland and European Health for All Database](#) and [Oregon Public Health Authority Vital Statistics Annual Report](#)

## Suicide in Scotland

The Committee also asked for information on the number of suicides in Scotland, broken down by age and gender. The largest numbers of suicides over the last five years have been in the following age-groups:

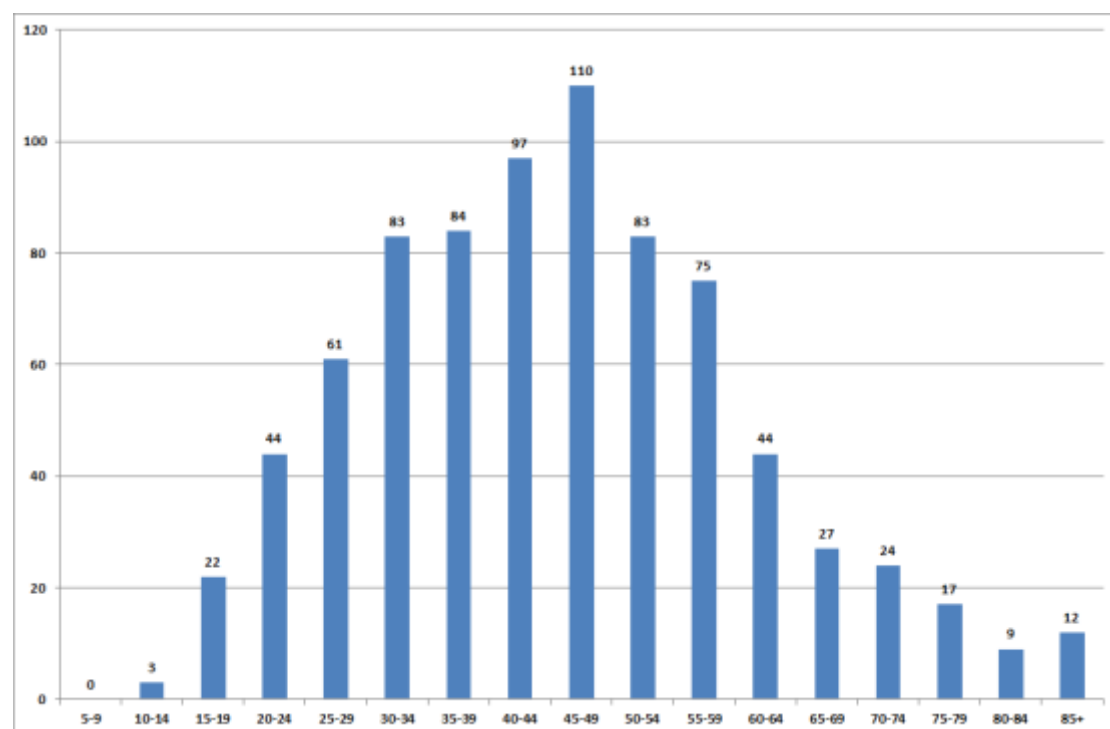


- 40-44 (98 per year on average)
- 45-49 (94 per year on average)
- 35-39 (82 per year on average)
- 50-54 (82 per year on average)
- 30-34 (72 per year on average).

However, the pattern has fluctuated over the years and the official statistics show that the proportion of suicides in the older age groups has generally decreased over the decades, with a larger proportion now occurring in the middle-aged groups. In 1974, 49% of suicides occurred in those aged 50+. This proportion then got markedly smaller up until 2000 (25%) before gradually increasing again to 38% in the present day.

At present the largest number of suicides occurs in the 45-49 age group (number = 110 in 2013). The following graph shows the number of suicides in the different age groups in 2013.

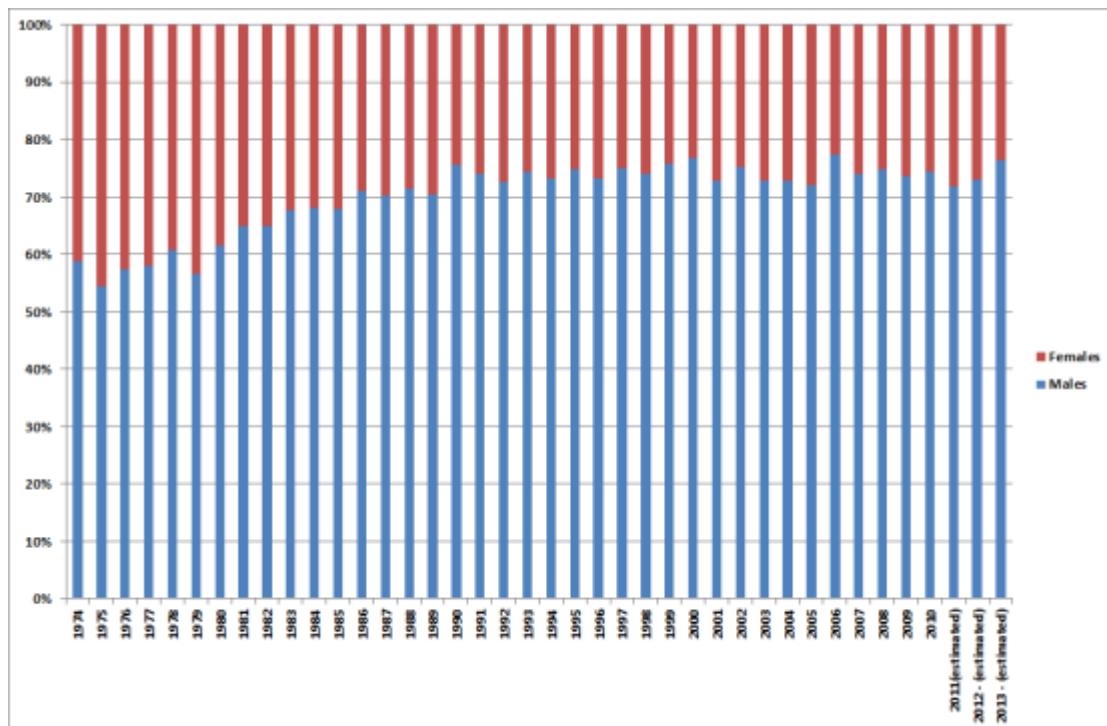
**Figure 5: Deaths for which the underlying cause was classified as 'intentional self-harm' or 'event of undetermined intent', by age group, 2013**



Source: GRO Scotland

The majority of suicides in Scotland occur in men, as shown in figure 6. This proportion has gradually increased from 59% in 1974 to 76% in 2013.

**Figure 6: Deaths for which the underlying cause was classified as 'intentional self-harm' or 'event of undetermined intent' by gender**



Source: GRO-Scotland

**Kathleen Robson**  
**SPICe Research**  
**12 February 2015**

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